COMMUNITY CARE COMMUNICATOR

CLIENT NAME	COUNTY	PSA NUMBER
ADDRESS (STREET AND NUMBER)	SOCIAL SECURITY NUMBER	MEDICAID NUMBER
CITY STATE ZIP CODE	DATE OF BIRTH	TELEPHONE NUMBER

SECTION I COMPLETED BY CARE COORDINATOR:

I. The client has elected to accept Community Care Services Program: Case Management began effective _____ and the client was placed in service effective _____.

- ☐ **The client is currently receiving MAO. Please calculate cost share.**
- ☐ **The client has been referred for eligibility determination and cost share.**
- ☐ **The client will require a home visit for application (Reason in Remarks).**

Signature_____ Telephone No._____ Date_____

SECTION II COMPLETED BY DFCS MEDICAID WORKER:

II. ☐ **The date client applied for MAO _____**

☐ **The client has been determined Medicaid eligible effective _____.**

☐ **The client is receiving Community Care Program Services and is responsible for contributing toward the cost.**

☐ **The client has a change in cost share.**

$ _____ EFFECTIVE _____ $ _____EFFECTIVE _____ $ _____EFFECTIVE _____

☐ **The client has been determined ineligible, effective _____ (Reason in Remarks).**

Signature _____ Telephone No. _____ Date _____

SECTION III COMPLETED BY CARE COORDINATOR:

III. The above named client is being released from the Community Care Services Program effective _____. for the following reason:

- ☐ **Client deceased; Date of Death _____**
- ☐ **Condition has improved; services no longer needed.**
- ☐ **Condition has worsened; entering a nursing home. Name, if known_____**
- ☐ **Other _____**

_____

Signature _____ Telephone No. _____ Date _____

SECTION IV COMPLETED BY CARE COORDINATOR or DFCS MEDICAID WORKER:

REMARKS: _____

_____

_____

Instructions
Community Care Services Program

COMMUNITY CARE COMMUNICATOR (CCC)

Purpose: The Community Care Communicator (CCC) provides information about clients entering the CCSP. The CCC is the primary line of communication between the DFCS MAO caseworker, care coordinator, and nursing home.

Who Completes/When Completed: DFCS and care coordinators use the CCC to share eligibility information and other changes in a client's situation, such as ineligibility, death, nursing home placement.

Instructions:

Enter the client's full name, complete address, county, social security number, date of birth, PSA number, Medicaid number, if known, telephone number (including area code), and the name, address and telephone number of any client representative.

Section I: Care coordinator completes all required information for MAO clients requesting cost share determination and potential MAO clients applying for Medicaid benefits and determination of cost share. Care coordinator forwards information to DFCS with a copy of the Level of Care (LOC) page and PMAO worksheet. Care coordinator indicates date care coordination began/case management, date client was placed in service, checks appropriate box identifying reason for referral to DFCS, signs and dates form. Care coordination/case management begins the day the care coordinator admits the client to CCSP/brokers service. The service date is the day the client receives the first waivered service. Care coordinator's telephone number, including area code, is written after signature.

Section II: DFCS Medicaid caseworker, upon receipt of CCC, begins the Medicaid eligibility process. Medicaid caseworker lists Medicaid number, completes Section III, and returns one copy of CCC or sends a computer-generated notice to the care coordinator. Medicaid caseworker notifies care coordinator of any changes affecting the recipient's eligibility or cost share liability. Medicaid caseworker signs and dates form.

Section III: Care coordinator notifies DFCS caseworker of changes in client's situation, including: change of address, change in financial circumstances, if client no longer receives a waivered service, or if client is terminated from CCSP.

Section IV: Care coordinator and DFCS caseworker use this section for additional comments such as directions to client home; name, address and telephone number, including area code, of client representative; client physical condition; reason client requires home visit by Medicaid caseworker and reason for eligibility termination.

Distribution: Care coordinator sends original of CCC and copy of LOC page to Medicaid caseworker at initial assessment and reassessment and retains a copy. Medicaid caseworker returns original with appropriate information or sends a computer-generated notice to care coordinator.

COMMUNITY CARE LEAD AGENCY
PROGRAMMATIC REPORT

PSA # _____ **DATE** _____ **MONTH** _____ **YEAR** _____

CONTRACTOR'S NAME (Lead Agency) _____

I. SCREENING INFORMATION

A. NUMBER OF UNSCREENED REFERRALS (Enter Manually)

1. Number of unscreened referrals carried over from previous months _____

2. Number of unscreened referrals received this month _____

3. Subtotal (I.A.1 + I.A.2) _____

B. NUMBER OF PENDED TELEPHONE SCREENS NEEDING ADDITIONAL INFORMATION _____

C. REFERRAL SOURCES FOR COMPLETED TELEPHONE SCREENS (INCLUDING SCREENED OUT REFERRALS):

1. Self _____
2. Family/Friend _____
3. Hospital _____
4. M.D. _____
5. DFCS _____
6. Nursing Facility (NF) _____
7. CCSP Provider (Exclude CCSP HDS) _____
8. Home Health Agencies (Include CCSP HDS) _____
9. Other _____

10. **TOTAL** (Add I.C.1 thru I.C.9) = _____

Form M-CCSP, Rev.3/00

PSA # _____ **DATE** _____ **MONTH** _____ **YEAR** _____

D. TELEPHONE SCREENINGS AND WAITING LIST

1. Screens on Waiting List Carried Over from Previous Month _____

2. New Telephone Screenings Completed this Month

a. Appropriate for CCSP- Add to Waiting List for Full Assessment + _____
b. Inappropriate for CCSP:
1. Needs, Services, Medical Problems Inappropriate + _____
2. Needs, Medical Problems too Great + _____
3. Financially Ineligible + _____
4. Refused Cost Share + _____
5. Refused Services + _____
6. Other Placement or Services + _____
7. Insufficient Information + _____
8. Other + _____
9. Total Inappropriate = _____

3. Total New Telephone Screenings Completed During Month
(I. D2a)+(I. D2b.9) = _____

4. Sub Total: Waiting for Full Assessment (I. D1) + (I. D2a) = _____
5. Waiting List Disposition:

a. Referred for CCSP Assessment _____
b. No longer appropriate for Waiting List:
1. Entered NF _____
2. Deceased _____
3. Needs, Services, Medical Problems Inappropriate _____
4. Needs, Medical Problems too Great _____
5. Financially Ineligible _____
6. Refused Cost Share _____
7. Refused Services _____
8. Other Placement or Services _____
9. Unable to Contact _____
10. Other _____
11. Total of b (5b1 through 5 b 10) = _____
c. Total Removed from Waiting List (5a +5b 11) _____

6. Telephone Screenings on Waiting List carried Over (I.D.4.-I.D5c.) = _____

PSA #_____ DATE _____ MONTH _____ YEAR _____

II. ASSESSMENT/REASSESSMENT INFORMATION

A. NUMBER OF REFERRED SCREENS NOT ASSESSED

1. Deceased	
2. Hospitalized	
3. Entered Nursing Facility	
4. Refused Services	
5. Refused Cost Share	
6. Unable to Contact	
7. Other	
8. Total Not Assessed	

B. ASSESSMENTS

1. Initial Assessments Performed	
2. Number of Completed Initial Assessments:	
a. 48 hours emergency assessments only	
b. 1-7 Days	
c. 8-14 Days	
d. 15-21 Days	
e. 22+ Days	
f. **TOTAL** (Add II.B.2a thru II.B.2e)	
3. Initial Assessments Pending	
4. Disposition of Completed Initial Assessments (same as II.B.2f):	
a. Recommended for CCSP	
b. Not Recommended for CCSP:	
1. Financially Ineligible	
2. Requires Immediate Institutional Care Without Further Assessment	
3. Failure to Meet Level of Care Requirements	
4. Needs, Medical Problems too Great	
5. Chooses NF Placement Due to Unavailable Alternatives	
6. Refuses Cost Share	
7. Refuses Services	
8. Other Placement or Services	
9. Other (Supplemental Report must have same #)	=
10.Total not recommended (Add II B.4 b1 thru II B.4b9)	
c. **TOTAL COMPLETED ASSESSMENTS** (II.B.4a.) + (II.B.4b.10.) (same as II.B.2f)	

PSA # _____ **DATE** _____ **MONTH** _____ **YEAR**_____

5. Medicaid Status of Initial Assessments Performed:

a. SSI Eligible	
b. MAO Eligible	
c. Referral to DFCS for Determination of PMAO Eligible	

d. Other _____

e. **TOTAL** (Add II.B.5a through II.B.5d) = _____

C. REASSESSMENTS

1. Purpose of Reassessments:

a. Reassessments Performed _____

b. Reason for Reassessments Performed:

1. Scheduled/Annual _____

2. Requested (No equivalent in CHAT) 0

3. Other _____

4. **TOTAL** = _____

2. Disposition of Reassessments Performed:

a. Recommend Continuation of CCSP _____

b. Recommend Termination from CCSP _____

c. Recommend NF Placement/Client Selected NF _____

d. Client Selected Other Placement _____

e. **TOTAL (**Same as II. C.1b4**)** = _____

PSA #_____ DATE _____ MONTH _____ YEAR_____

III. CLIENT INFORMATION

A. CLIENTS SERVED:

1. Clients Carried Over From Previous Month _____

2. New Clients + _____

3. Reinstated From Previous SFY + _____

4. Reinstated From This SFY + _____

5. Transferred In From Another PSA + _____

6. Subtotal (Add III.A.1 thru III.A.5) = _____

7. Transferred Out To Another PSA = _____

8. Terminated From Service = _____

9. **TOTAL ACTIVE - END OF PERIOD** = _____

B. MEDICAID STATUS OF CLIENTS:

1. SSI Eligible _____
2. MAO Eligible _____
3. Potential Medical Assistance Only _____
4. Other _____
5. **TOTAL** (Add III.B.1 through III.B.4) = _____

C. NUMBER OF CLIENTS TERMINATED BY CATEGORY:

1. Determined No Longer Eligible/Appropriate at Reassessment _____
2. UR Recommended Termination _____
3. No Service In 60 Days _____
4. Expired _____

PSA #_____ **DATE** _____ **MONTH** _____ **YEAR**_____

5. Client Requested Termination _____
6. Client Moved Out of State _____
7. Client Entered NF (Supplemental must have same #) _____
8. Other (Supplemental must have same #) _____
9. No Longer Meets Level of Care Criteria _____
10. **TOTAL** _____

***For the following items with * enter information manually*:**

		MONTH	**SFYTD**
D.	NUMBER OF COMPLETED CCP REVIEWS	_____	N/A
E.	UNDUPLICATED NUMBER OF CLIENTS SERVED*	N/A	_____
F.	NUMBER OF INDIVIDUALS IN PROCESS*	_____	N/A
G.	NUMBER OF CLIENTS PROJECTED TO DRAW DOWN MEDICAID $ *	_____	N/A
H.	EXPENDITURES AUTHORIZED FOR CCSP*	_____	_____
I.	PERCENT OF ALLOCATION AUTHORIZED YTD (SFYTD) divided by Annual Allocation)*	N/A	_____
J.	MONTHLY/YTD SAF PER INDIVIDUAL CCSP CLIENT*	_____	_____
K.	AVERAGE YTD DEAUTHORIZATION RATE *	N/A	_____
L.	NUMBER OF CLIENTS TO ADD OR SUBTRACT *	_____	N/A

I certify that these figures are accurate to the best of my knowledge. _____
Date

_____ _____ _____
Name Signature Title

_____ (___) _____
Name of Person Completing Report Telephone Number

Instructions

Community Care Services Program

COMMUNITY CARE LEAD AGENCY PROGRAMMATIC REPORT (M-CCSP)

Purpose: The Division of Aging Services and the AAAs use information from the Programmatic Report to:

1. Meet federal and state reporting requirements
2. Determine if program objectives are being met
3. Track and calculate whether programmatic budget limitations are being observed
4. Provide information to the General Assembly and others regarding CCSP.
5. Provide information to determine how many clients Care Coordination may add or subtract each month on local and statewide levels.

Who Completes/When Completed:

1. Care coordination or a designee using information provided by CHAT and AIMS completes all of the report except for items K. (The Average SFYTD Deauthorization Rate) and L. (The Number of Clients to Add or Subtract) and forwards the report to the Area Agency on Aging on or before the 5th business day of the month following the report month.

2. The AAA or a designee completes items K. and L. of the report upon receipt. It is the AAAs responsibility to assure determination of the Average Deauthorization Rate and to assure programmatic report information is entered into the CCSP tracking document to complete items K. and L. This information is used by AAA to inform Care Coordination of the number of clients that may be added or subtracted at the local level. Upon completion of items K. and L. the AAA Director approves, signs and has the report faxed to the Division of Aging Services.

Instructions:

Enter data in every blank. Blanks with no data are interpreted by the Division as missing or unreported data, therefore enter a "0" for items having no activity. **Do not modify this form.**

PSA NUMBER: Enter PSA number in the space provided on each page of this report.

DATE: Enter date the report was completed in the space provided on each page of this report.

MONTH/YEAR: Enter calendar month and year in the space provided on each page of this report.

CONTRACTOR'S NAME: Enter the name of the AAA /Lead Agency.

NOTE: Most of the time CHAT uses status codes to calculate data; therefore, it is essential that status codes be completed correctly on each client.

SECTION I: SCREENING INFORMATION

A. NUMBER OF UNSCREENED REFERRALS

1. Enter manually the number of unscreened referrals from *previous* months. This includes referrals where there has been *no contact* as of the end of the report month. It also includes referrals *not entered into the computer* as of the end of the report month.
2. Enter manually the number of unscreened referrals received *this reporting month*. This includes referrals where there has been *no contact* as of the end of the report month. It also includes referrals *not entered into the computer* as of the end of the report month.
3. Subtotal (I.A1+I.A2)

B. NUMBER OF PENDED TELEPHONE SCREENS NEEDING ADDITIONAL INFORMATION

CHAT enters the number of telephone screens at the end of the report month where some contact was made but more information is needed before the screen can be completed. This includes screens from previous months and from the report month.

C. REFERRAL SOURCES FOR COMPLETED TELEPHONE SCREENS (INCLUDING SCREENED OUT REFERRALS)

The information in this section is taken from completed telephone screenings. **Include referrals that were screened out.** CHAT calculates and enters the following:

1. Number of self referrals (applicant).
2. Number of referrals made by family or friends of applicant.
3. Number of referrals made by hospitals.
4. Number of referrals made by applicant's physician.
5. Number of referrals made by DFCS.
6. Number of referrals made by a nursing facility.
7. Number of referrals made by CCSP providers (exclude CCSP HDS Providers).
8. Number of referrals made by Home Health Providers (including CCSP HDS Providers.).
9. Number of referrals made by other sources.
10. Total referral sources of completed telephone screens in this reporting month (add I.C1 through I.C9).

D. TELEPHONE SCREENINGS AND WAITING LIST:

1. CHAT enters number of telephone screened clients on the waiting list carried forward from last reporting month.

2. CHAT enters the number of telephone screened clients (including those screened out) for this month in the following categories.

   a. Number of applicants screened who were appropriate for the CCSP and were added to the waiting list for full assessment.

   b. Number of applicants screened out as inappropriate for the CCSP:

      1. Number of applicants screened out because needs, services, and medical problems made them inappropriate for the CCSP, includes MH/MR diagnosis.
      2. Number of applicants screened out because medical problems too great.
      3. Number of applicants screened out for financial ineligibility.
      4. Number of applicants screened out for refusal to pay cost share.
      5. Number of applicants screened out because services refused.
      6. Number of applicants screened out for other placement services (e.g. Hospice, Medicare Home Health, or Family meeting needs).
      7. Number of applicants screened out for insufficient information.
      8. Number of applicants screened out for any other reason.
      9. Total number of applicants inappropriate for the CCSP this reporting month (add b 1 through b 8).

3. CHAT enters the total number of new telephone screenings completed during the report month (I.D2a + I.D2b9).

4. CHAT enters the total number of applicants waiting for full assessment (I.D1 + I.D2a).

5. Waiting List Disposition:

   This section reports the reasons applicants were removed from the waiting list during the report month.

   CHAT calculates and enters the following:
   a. Number of applicants referred for CCSP assessment.
   b. Number of applicants removed from the Waiting List for the following:

      1. Entered a nursing facility.
      2. Deceased.
      3. Needs, services, medical problems were inappropriate.
      4. Needs, medical problems were too great.
      5. Financially ineligible.
      6. Refused to pay cost share.
      7. Refused services.
      8. Other placement or services.
      9. Unable to contact

10. Other
11. Subtotal of persons removed from the waiting list 5 b1-5 b10.

c. Total number of applicants removed from the waiting list (add I.D5a + I.D 5b11).

6. CHAT enters total number of telephone screenings on the waiting list carried forward to next reporting month (I.D4 - I.D-5c).

SECTION II: ASSESSMENT/REASSESSMENT INFORMATION

This section contains data from care coordinators relating to care coordinator activities during the reporting month. CHAT enters the following:

A. THE NUMBER OF REFERRED SCREENS NOT ASSESSED

1. Applicant deceased
2. Applicant hospitalized
2. Applicant enters a nursing facility
4. Applicant refused services
5. Applicant refused to cost share
6. Unable to contact client
7. Other
8. Total not assessed.

B. ASSESSMENTS: CHAT enters the following assessment information.

1. Initial Assessments Performed: This is the number of face-to-face initial assessments performed this month.

2. Number of Completed Initial Assessments: The number of completed initial assessments includes those assessments where the signed level of care page has been returned from the doctor and the LOC/Recommendation for CCSP has been assigned this month. This number also includes initial assessments that were not recommended for CCSP this month.
   a. Number of emergency assessments ONLY.
   b. Number of assessments completed within 1 - 7 days.
   c. Number of assessments completed within 8 - 14 days.
   d. Number of assessments completed within 15 - 21 days.
   e. Number of assessments completed within 22 days or more.
   f. Total initial assessments completed within report month (add II.B2a through II.B2e).

NOTE: CHAT uses status codes to calculate and enter the number of calendar days to complete an assessment; therefore it is essential that status codes be completed correctly on each client.

3. Initial Pending Assessments: This includes any initial assessment where the home visit has been completed but the level of care has not been assigned during the report month. The initial assessment could have been performed in another report month.

4. Disposition of Completed Initial Assessments:

   Data from CHAT status codes is used to complete this portion of the report. Totals in this portion of the report are the same as totals provided in Item II. B(2)(f).

   a. CHAT enters number of applicants recommended for the CCSP.

   b. CHAT enters the number of assessed applicants who were not recommended for the CCSP for the following reasons.

      1. Applicants found financially ineligible.
      2. Applicants requiring immediate institutional care.
      3. Applicants failing to meet Level of Care (LOC) requirements (Use Item 40 on the 5588).
      4. Applicants whose needs, medical problems are too great.
      5. Applicants choosing nursing homes due to unavailable alternatives (e.g., services needed are unavailable in PSA).
      6. Applicants refusing to cost share.
      7. Applicants refusing services.
      8. Applicants choosing other placements or services.
      9. Applicants not recommended to the CCSP for other reasons. (Supplemental must have same #)
      10. Total applicants NOT recommended for the CCSP in the reporting month(add II.B.4b1 through II.B.4b9).

   c. Total number of assessments disposed of in report month (II.B.4a + II.B.4b10), Same as II. B.2f.

5. Medicaid status of persons assessed: CHAT enters the following:

   a. Number of persons SSI Medicaid eligible.
   b. Number of persons MAO eligible. This includes QMB, Public Law, Katie Becket and any other category of Medicaid other than SSI.
   c. Number of persons referred to DFACS for determination for PMAO.
   d. Number of MAO/PMAO persons assessed for other reasons. (Services paid entirely by Medicare or cost share.)
   e. Totals for Medicaid status of persons assessed in report month. (II.B.5a through II.A.5d). This total is the same as II-B.4c.

C. REASSESSMENTS:

1. Purpose of Reassessments: CHAT enters the following reassessment data:

a. Reassessments Performed: The number of reassessments visits performed this report month.

b. Reasons for Reassessments Performed: The number of reassessments performed this month that were:

1. Scheduled/annual reassessments (e.g., fixed intervals.)
2. Requested by care coordinator. (There is no equivalent in CHAT. This figure will always be "0".
3. For other reasons, (This includes any reassessment other than fixed interval.)
4. Total number of reassessments performed this month, total of II.C1b. 1-3. This number is the same as II.C1a.

2. Disposition of Reassessments Performed: CHAT enters the following for the report month:

a. Number of reassessments recommended for continuation in the CCSP.
b. Number of reassessments recommended for termination from the CCSP.
c. Number of reassessments recommended for NF placement/client selected NF.
d. Number of reassessments where client selected other placement.
e. Total number of reassessments performed this report month (Add II.C.b2a thru b2d). This total is the same as (II.C1b4) above.

III. CLIENT INFORMATION

CHAT enters the following:

A. 1. Number of clients carried over from last month. This is the number from line III. A9 of last month's report.)
2. Number of new clients brought into the CCSP during this report month.
3. Number of clients reinstated from previous SFY during this report month.
4. Number of clients reinstated during current SFY in this report month.
5. Number of clients transferred in from another PSA during this report month.
6. Subtotal of clients served during report month (Add III.A1 thru III.A5).
7. Minus number of clients transferred out of PSA during report month.
8. Minus number of clients terminated from services during report month.
9. Total number of clients in active case load at the end of report month (III.A6-III.A7-III.A8).

B. MEDICAID STATUS OF CLIENTS:

1. Number of active clients who are SSI Medicaid eligible.
2. Number of active clients who are MAO eligible. (This includes QMB, Public Law,

Katie Becket, and any other category of Medicaid other than SSI.)

3. Number of active clients who are PMAO eligible.
4. Number of MAO/PMAO active clients who are eligible but not using Medicaid dollars, (e.g., waivered services are totally paid by Medicare or client's cost share).

5. Total Medicaid status of all active clients at the end of report month (Add III.B1 thru III.4). This total is the same as III.A9.

C. NUMBER OF CLIENTS TERMINATED BY CATEGORY:

1. Number of clients no longer eligible/appropriate at reassessment.
2. Number of clients recommended for termination by UR.
3. Number of clients who received no service in past 60 days.
4. Number of clients who expired in report month.
5. Number of clients who requested termination of services.
6. Number of clients who moved out of state.
7. Number of clients who entered a nursing home. (Must have same # on Supplemental Report)
8. Number of clients who were terminated for any other reason. (Must have same # on Supplemental Report)
9. Number of clients who no longer meet level of care.
10. Total number of clients terminated in report month (Add III.C1 thru III.C9). This total is the same as III.A8.

D. NUMBER OF COMPLETED CCP REVIEWS:
CHAT enters the number of completed CCP reviews in the report month.

E. UNDUPLICATED NUMBER OF CLIENTS SERVED:
Manually enter the number of unduplicated clients served in SFYTD. This information will be provided by the AIMS unduplicated client count report.

F. NUMBER OF INDIVIDUALS IN PROCESS:
Manually enter number of individuals in process at the end of report month. This number includes persons whose initial assessment has not been returned from physician and initial clients whose data has not been entered in AIMS at the end of the report month.

G. NUMBER OF CLIENTS PROJECTED TO DRAW DOWN MEDICAID FUNDING:
Manually enter the number of CCSP clients who are projected to draw down Medicaid dollars at the end of report month. Add (III.B1 through III.B3) + (III-F)] to calculate the projection.

H. EXPENDITURES AUTHORIZED FOR CCSP BENEFITS:
Manually enter expenditures for all active clients at the end of report month and SFYTD. Use the figures from the AIMS Service Authorization Summary, for the reporting month.

List the "Net Total Authorized" for reporting month and the "Cumulative Net Total" for SFYTD.

I. PERCENT OF ALLOCATION AUTHORIZED YTD:
Manually enter percent of CCSP allocation after it has been deauthorized SFYTD, including report month. Divide the total service benefit funds authorized after it has been deauthorized SFYTD (in Item H above) by the annual PSA total allocation for the CCSP. This calculation helps the AAA determine if spending is on track for the year.

J. MONTHLY/YTD SAF COST PER INDIVIDUAL CLIENT:
Manually enter both the monthly and SFYTD SAF cost per CCSP client. This information is obtained from the month/total column on the AIMS Service Authorization Summary Report.

K. AVERAGE SFYTD DEAUTHORIZATION RATE:
Manually enter the average SFYTD deauthorization rate. Use the average SFYTD de-authorization rate from the past SFY until the first deauthorization occurs in the current fiscal year. Thereafter, use the average SFYTD deauthorization rate for the current fiscal year. Calculate and manually enter both the reporting month and average SFYTD deauthorization rates.

L. NUMBER OF CLIENTS TO ADD OR SUBTRACT:
Manually enter the number for the report month from Column S of the Authorization and Allocation Tracking Worksheet. Enter a (+) sign if the clients are to be added to the slots currently in effect and enter a minus (-) sign if the number of clients are to be subtracted from those currently in effect.

1. Enter the name of the AAA contact person authorized to certify the programmatic report.
2. Enter the signature of the AAA contact person.
3. Enter the title of the AAA contact person.
4. Enter the date the AAA contact person signs the report.
5. Enter the name of the person completing the report.
6. Enter the telephone number and area code of the person completing the report.

Distribution:

1. The care coordination completes the report and sends the original to the AAA within the deadline set by the AAA.

2. The AAA Director signs and dates indicating that the report is accurate and faxes the report to the Division within 5 business days after the reporting month.

3. The AAA Director mails the hard copy original and 3 copies: Director, Division of Aging Services; Two Peachtree Street, N.W., Suite 9.398, Atlanta, GA 30303-3176 within 10 business days after the reporting month.

Supplemental Information to Programmatic Report

AAA _____ Date _____ Report Month/Year_____

I. Nursing Home Admissions Please indicate reasons below why terminated clients go into nursing homes	
Reason	**Number**
A. **CLIENT PLACED IN NH, *NO HOSPITALIZATION***	
1. Client suffered an *acute* medical episode that resulted in a rapid decline in health	
2. Caregiver support breakdown	
3. Client experienced a *steady* progressive decline in health	
4. Client experienced a fall or fracture	
5. Other: **Please define reasons other than those listed above**	
Subtotal	
B. **CLIENT WAS PLACED IN NH FROM HOSPITAL**	
1. Client suffered an *acute* medical episode that resulted in a rapid decline in health	
2. Caregiver support breakdown	
3. Client experienced a *steady* progressive decline in health	
4. Client experienced a fall or fracture	
5. Other: define reasons other than those listed above	
Subtotal	
TOTAL NUMBER of clients transitioned to Nursing Homes	

II. Disposition of Completed Initial Assessments	
4b. Not Recommended for CCSP	
9. Other **Please define reason**	

III. Number of Clients Terminated by Category	
Other: define why clients were terminated under the category	**Number**
1.	
2.	
3.	

IV. Waitlist	
1. Number of clients on waitlist that are receiving non-CCSP services pending CCSP admission	
2. Average number of months those admitted to CCSP were on wait list before admission to CCSP	
Screenings	
1. Total re-screens completed this month	
2. Number of re-screens needed to be done that are 120 days or older	

V. Summary of Monthly Supervisory Review

Problem/Issue	Corrective Action Plan
Triggers	
Triage Levels	
Case load size	
Observations of weight, skin & meds	
Hospitalizations	
Minimal Services	
Review of LOC	
Clinical Records Read (ALS & ADH) Completion of Checklists	
Latest Policies and Procedures	
Celebrate Comprehensive Care Coordination Activities	
Other	

Instructions
Community Care Services Program

COMMUNITY CARE LEAD AGENCY SUPPLEMENTAL REPORT (S-CCSP)

Purpose: The Division of Aging Services and the AAAs use the drill down information from the Supplemental Report to determine:

1. The reasons clients were terminated and are placed in Nursing Homes with or with out hospitalization (III.C.7 on the Programmatic Report)
2. The reasons clients are not recommended for CCSP under Disposition of Completed Initial Assessments, "other" (II.B.4.9 on the Programmatic Report)
3. The reason clients were terminated under the Number of Clients Terminated by Category "other" (III.C.8. on the Programmatic Report)
4. The number of persons on the waiting list that are receiving non-CCSP services pending CCSP admission and the average time clients were on the waiting list prior to CCSP admission
5. Monthly supervisory activities at the care coordination level

Who Completes/When Completed:

Care coordination completes Section I, Section II, Section III, and Section IV and forwards the information to the AAA. The AAA completes Section IV. The report is completed and due at the same time as the Programmatic Report. The Supplemental Report is attached to the Programmatic Report and submitted to the Division of Aging Services.

Instructions:

Enter data in every blank if applicable. If there is no activity enter a "0" or "NA."

AAA: Enter the AAA name.

DATE: Enter the date the report was completed in the space provided.

REPORT MONTH/YEAR: Enter the reporting month and the year in the space provided.

SECTION I: Nursing Home Admissions

A. CLIENT PLACED IN NH, NO HOSPITALIZATION

1. Enter the number of clients that suffered an *acute* medical episode that resulted in a rapid decline in health.
2. Enter the number of clients where there was caregiver support breakdown.

3. Enter the number of clients who experienced a *steady* progressive decline in health

4. Enter the number of clients who experienced a fall or fracture.
5. Enter the number of clients who are not covered in 1-4 and define **the reason(s)** in the space provided.

Add the numbers for 1-5 and enter the subtotal.

B. CLIENT WAS PLACED IN NH FROM HOSPITAL

1. Enter the number of clients that suffered an *acute* medical episode that resulted in a rapid decline in health.
2. Enter the number of clients where there was caregiver support breakdown.
3. Enter the number of clients who experienced a *steady* progressive decline in health
4. Enter the number of clients who experienced a fall or fracture.
5. Enter the number of clients who do not fall into 1-4 and define **the reason(s).**

Add the numbers for 1-5 and enter the subtotal.

Add the two subtotals together and enter the number in the **TOTAL NUMBER of client's transition to Nursing Homes.**
NOTE: The total figure should agree with III.C.7 on the Programmatic Report

SECTION II. **Disposition of Completed Initial Assessments**
Enter the number of clients not recommended for CCSP and define the reason(s).

NOTE: This number should be the same as the number on II.B4.b.9 of the Programmatic Report.

SECTION III. Number of Clients Terminated by Category

Enter the number of clients that were terminated under the category "other" and define the reason(s) they were terminated.

NOTE: This number should agree with III.C.8 of the Programmatic Report.

SECTION IV: Waitlist

1. Enter the number of clients on the waitlist that are receiving non-CCSP services pending admission to CCSP.
2. Enter the average number of months those admitted to CCSP were on the waitlist before admission to CCSP.

SECTION V. Summary of Monthly Supervisory Review
Write in the space provided by each problem and issue listed any activity that took place during the reporting month and if appropriate any corrective action that will be taken as result of the monthly

supervisory reviews of 10% or the case records.

Community Care Services Program

COMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

1. Check (T) the appropriate box to indicate the reason for sending the CCNF:
   ( ) Initial ( ) Change ( ) Complaint / Concern ( ) Transfer ( ) Discharge

2. To _____ Date _____

3. From _____ Telephone (_____) _____
   (Agency name)

4. Client name _____ Telephone (_____) _____

5. Client address _____
   City _____ Zip _____ County _____
   ( ) Check if new address

6. Date provider completed initial evaluation of client _____

7. Services accepted: ( ) No - Reason _____
   _____
   ( ) Yes - Date service began _____
   - Frequency / Units _____

8. Client status change:
   ( ) Request for service increase ( ) Request for information
   ( ) Request for service decrease ( ) Client request for provider change
   ( ) Client in hospital ( ) Client termination
   ( ) Client out of home ( ) Other

9. Effective date of change _____

10. Discharge (briefly describe actions leading up to need for discharge process) _____
    _____

11. Date discharge (30-day) letter sent _____ Actual discharge date _____

12. Are services continuing through 30-day notice? ( ) Yes ( ) No

Explain _____

13. If complaint or concern, be specific _____
    _____

14. Comments _____
    _____
    _____

15. Sender's Signature _____ Title _____

16. Recipient's Signature _____ Date _____

17. Response _____

Instructions
Community Care Services Program

COMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

Purpose: Providers and care coordinators use the CCNF to share information about clients.
Who Completes/When Completed: Provider and care coordinators use CCNF to advise each other regarding client services and other information, such as hospitalization, death, etc.

Instructions:

1. Use a check (✓) mark to indicate the reason for completion of the CCNF.

2. Enter the individual's name to whom the CCNF is being sent and the date.

3. Enter the name and telephone number (including area code) of the agency completing the CCNF.

4. Enter the complete client name, area code and telephone number.

5. Enter the client's mailing address, including city, zip code and county of residence. Check (✓) if the address is new.

6. Indicate whether the client has accepted CCSP services. If no, give the reason. If yes, give the date service began. Secondly, indicate the frequency of service, and the units per month. Follow up and report back to sender within 3 business days.

7. Enter date provider completed initial evaluation of client.

8. Check (✓) the reason for the CCSP client status change.

9. Indicate the effective date for a CCSP provider service change.

10. Describe briefly the actions leading up to a discharge of the CCSP client.

11. Indicate the date that the provider mailed the 30-day discharge letter. Give the actual discharge date.Check (✓) "yes" or "no" to indicate whether services will continue through the 30-day notice of discharge. Provide necessary explanation.

12. If sending a CCNF because of a complaint or concern, give specific details.

13. Provide other comments, if necessary.

14. Sender types name or signs the form and indicates work title.

15. Recipient types name or signs the form and records the date.

16. Note any recipient response to the CCNF.

Distribution: If the Provider initiates the CCNF the original is sent to the care coordinator and the Care coordinator returns CCNF original within three business days and files copy in client case record. Likewise if the Care Coordinator initiates the CCNF the original is sent to the provider and the provider returns the original CCNF within three business days and the care coordinator files the original in the clients record.

If sent electronically, print a copy and file in client case record.

Community Care Services Program

COMMUNITY CARE SERVICES PROGRAM PARTICIPATION, FORM 5389

Dear _____: Date _____

Welcome to the Community Care Services Program (CCSP). The CCSP Registered Nurse (RN) reviewed your situation and recommended community-based services through CCSP.

Services will begin after the providers listed below have visited you. Someone from the following service agency will be contacting you within a week from the date of this letter.

1. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

2. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

3. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

4. _____
Provider Agency

_____
Contact Person

(____) _____
Telephone Number

As a participant in the Community Care Services Program:

1. You will not lose any medical assistance benefits that you are currently receiving by participating in the Community Care Services Program.

2. You may withdraw from the CCSP at any time.

Please contact the care coordinator listed below by _____ to discuss your services. You may have someone call on your behalf.
(Date)

_____ (____) _____
Care Coordinator Telephone Number

Instructions
Community Care Services Program

CCSP PARTICIPATION, FORM 5389

Purpose: This form is used to notify the client of acceptance into the CCSP and to advise that someone will be in contact to provide services. Furthermore, it serves as a tickler to the care coordinator to check to see if services have begun.

Who Completes/When Completed: The care coordinator completes Form 5389 when services have been brokered with providers.

Instructions:

Date:	Enter date services were brokered with provider.
Greeting:	Enter client's name.
Provider Agency:	Enter name(s) of provider agency chosen by client or by rotation system.
Contact Person:	Enter name(s) of person(s) within provider agency that client or family member may contact, if necessary.
Telephone Number:	Enter telephone number(s) of provider agency.
Care Coordinator:	Enter signature of care coordinator assigned to case.
Date:	Enter date client/representative will contact care coordinator to follow- up on services. If client fails to call, care coordinator contacts client.
Telephone Number:	Enter the care coordinator's telephone number, including area code.
Distribution:	Original - Client Copy - Client case record.

NOTE: It is suggested that the copy be placed in a tickler file until the client contacts care coordinator. If the client fails to contact the care coordinator, the tickler is a reminder for the care coordinator to contact the client. The copy may then be placed in the case record.

Georgia Department of Human Resources

COMMUNITY CARE SERVICES PROGRAM

Service Order

Client Name	SSN	Medicaid #	Care Plan Type	Recommendation	Date	Next Care Plan	Triage Code
Jane Doe	001-00-0001				2114/2005		

Medicaid Card Checked

Comments

Skin Integrity Change **Weight Change** **Medication Change**

 # MD Visits **# ER Visits** **# Hospitalizations**

Service	Provider	Phone	C Freq	Units Cost	Ordered	Begin	End
Personal Support Services			☐	0			

Name John Doe ☐ **Client Signature on File** **Signature Date**

Signature Date

☐ **Client Chose CCSP vs. Nursing Home Placement**

Signature Date

Care Coordinator _____

Collaborating Team Member _____

Instructions
Community Care Services Program

COMPREHENSIVE CARE PLAN (CCP) SERVICE ORDER

Purpose: The care coordinator uses the Service Order of the CCP to describe the client's service needs.

Who Completes/When completed: The care coordinator completes the Service Order at initial assessment, 60-day review, comprehensive care plan review, and reassessment.

Instructions:

NOTE: These numbered items correspond to CCP Service Order screen items in CHAT.

1. Enter name of client.

2. Enter Social Security number (SSN) of client.

3. Enter Medicaid number of client. Leave this item blank if the client is a PMAO client who does not have a Medicaid number at this point.

4. Enter care plan type, i.e., Initial, 30 day, CCP Review, Reassessment, or Interim.

5. Indicate care coordination team's recommendation for client.

   NOTE: Use Interim care plan type to make changes-adding/deleting provider, frequency of service-- between reviews or reassessment and no review or reassessment is required.

6. Enter date the Service Order is completed.

7. Indicate date of next care plan review or double click to enter a date four months from care plan date. If this is an initial assessment, the next CCP Review will be due 60 days from the date services were brokered.

8. Use the Comments section to explain why services were ordered, changed, discontinued, etc., or to add any specific information regarding any services being provided to client or to alert provider with specific instructions. Include discharge plan recommendations and informal support. If completing a care review and reassessment at the same time, document this information in the Comments section.

9. Service: Use the drop list to record all services including CCSP which the client currently receives. At initial assessment, use the comments section to document services received in the past three months that are now terminated. The care coordinator uses the client's input

to develop the care plan services. For informal support services, use InfS for the name of the service.

10. Enter name of provider, including non-CCSP providers. For informal support services, indicate caregiver's relationship to client.

11. Enter the telephone number including area code of provider agency.

12. Indicate whether the CCSP provider was the client's choice or was selected from the rotation list. If the client chooses a provider, but the care coordinator does not broker service with the selected provider, document an explanation in case notes.

13. Enter the frequency of service to be provided. For non-CCSP services, including informal support services, enter frequency of service if known.

14. Enter the units of service to be provided. For non-CCSP services enter units of service if known.

15. Enter the estimated Medicaid cost per month for the service to be provided. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS $ x 30 units per month = $). Use current provider rates to determine cost per month. *If total cost of client services is expected to exceed cost cap consistently, client may not be appropriate for CCSP*. For non-CCSP services leave estimated cost blank.

16. Enter the date the CCSP service is ordered/brokered.

17. Enter the date the CCSP service began as indicated on the initial Community Care Notification Form (CCNF). Leave blank at initial face-to-face assessment and enter the date in CHAT when the CCNF is received from the provider(s).

18. Enter the date any service ended/terminated.

19. Enter the payment/fund source for CCSP and non-CCSP services if known. NOTE: This includes Medicaid Home Health Services. Any deviation from the care plan is discussed and explained in Comments section.

20. Signature of care coordinator who completed this care plan.

21. Indicate date care coordinator signed the care plan.

22. Signature of collaborating team member and date signed needed at initial assessment and reassessment. This signature is not needed for CCP reviews and Interim CCPs.

    NOTE: Care coordinator who completes assessment/reassessment signs CCP at time of assessment. Collaboration team member signs prior to form being sent to physician for review and completion.

23. Indicate whether client chooses CCSP or nursing home placement. Have client or representative sign the signature page to indicate the choice.

24. Indicate if client or representative signed signature page.

25. Enter date client or representative signed signature page.

Distribution: At initial assessment and reassessment, send LOC page, medication list, and CCP Service Order to physician for review and completion. Upon return from physician, maintain care plan in client file and send copies to providers delivering services to the client. At care reviews, send copies to providers.

Community Care Services Program

INITIAL HEARING SUMMARY

I. Date verbal request received _____
Date written request received _____

IIA. Client name _____
Social Security number _____
Address _____
_____
Telephone ( ) _____

B. Client Representative _____
Address _____
Relationship to client _____
Telephone ( ) _____

IIIA. Agency name _____
Agency address _____
Telephone ( ) _____
_____

B. Area Agency on Aging (AAA) _____
AAAA address _____
Telephone ( ) _____

C. CCSP providers affected (Attach additional sheets if necessary):
Names Addresses
_____
_____
_____
_____

IVA. Adverse action being appealed:
1. ____ Denial/termination of Level of Impairment
2. ____ Denial/termination of Level of Care
3. ____ Denial/termination based on health and safety risks
4. ____ Reduction/termination of service by DMA Utilization Review
5. ____ Reduction/termination of service by care coordination
6. ____ Other denial/termination
Explanation of other denial/termination being appealed:
_____
_____

B. Services continuing pending hearing ____ Yes ____ No

C. Is Medicaid eligibility affected? ____ Yes ____ No
If "Yes", Was DFCS Notified ____ Yes ____ No

V. Suggested hearing site _____

VI. Signed _____ Title _____
Screening Specialist/Care Coordinator signature

Date _____

VII. Other than client, screening specialist or care coordinator, and Division of Aging Services, individuals authorized to receive a copy of hearing notices:
Name _____
Address _____
_____
_____
Telephone (____) _____

Name _____
Address _____
_____
Telephone (____) _____

VIII. The following documents or copies are attached:

1. Completed and signed Request for Hearing, Form 5383
2. Telephone Screening Assessment (DON-R)
3. Most recent Level of Care, MDS-HC, and CCP, if applicable
4. Adverse action notice sent to the client
5. Completed Hearing Summary Form
6. Any documents, medical records, and other materials on which the agency relied for the adverse action
7. Excerpts from regulations supporting the adverse action notice.

Cc: Division of Aging Services

Instructions
Community Care Services Program

INITIAL HEARING SUMMARY

Purpose: The Initial Hearing Summary Form provides the Office of State Administrative Hearings with a summary of critical information necessary for the Administrative Law Judge to prepare for a hearing.

Who Completes/When Completed: The screening specialist or care coordinator completes the hearing summary when initial appeal requests are made, even when the client appeals directly to the DHR Legal Services Office.

Instructions:

I. Enter date verbal request was received.
Enter date written request was received.

IIA. Enter name of person requesting hearing.
Enter social security number of client requesting hearing.
Enter address of person requesting hearing.

B. Enter name of client's authorized representative (if applicable).
Enter address of client's authorized representative (if applicable).
Enter relationship of authorized representative to client (if applicable).

IIIA. Enter name of agency denying or terminating the case.
Enter agency's address.
Enter area code and telephone number of agency.

B. Enter name of AAA, address, and telephone number of AAA in planning and service area where client's appeal will be held.

C. Enter names and addresses of all CCSP providers who are affected by decision being appealed by client.

IVA. Check (T) type of action being appealed.
Enter any other action being appealed which is not listed above.

B. Services continuing pending hearing: check (T) appropriate response.

C. Is Medicaid eligibility affected: check (T) appropriate response.

V. Enter suggested hearing site based on physical and/or mental capability of client.

VI. Enter signature of screening specialist or care coordinator completing this form.
Enter date form was completed.

VII. List the name, address, and telephone number of individuals for whom the client has authorized on an Authorization of Release Form.

VIII. Attach all documents or copies included in the list to the Request for Hearing Form.

Distribution: Attach the Hearing Summary Form to the original documents and mail to the DHR Legal Services Office and a copy to the care coordination specialist assigned to your area. File a copy in the client's case record. See Chapter 1000 for reference.

Georgia Department of Human Resources
Division of Aging Services
Community Care Services Program

INITIAL SERVICE AUTHORIZATION DATA ENTRY FORM

Medicaid Number _____ Social Security Number _____-_____-_____

Client's Name _____ Services Begin Date _____/_____/_____

NOTE: If client is MAO, for each provider assigned to collect cost share, enter 99999 as the procedure code for the client's liability.

Services Authorized			**Month /**		**Month /**		**Month /**	
Complete Provider Name	**Service Name**	**Procedure Code**	**Units**	**Client Liab.**	**Units**	**Client Liab.**	**Units**	**Client Liab.**

Care Coordinator: _____ Date: _____/_____/_____ Rev. 10/99

Instructions
Community Care Services Program

INITIAL SERVICE AUTHORIZATION DATA ENTRY FORM

Purpose: The Initial SAF Data Entry Form is used to provide information to data entry for AIMS. This information authorizes the number of service visits, the cost of services and the provider who provides each service.

Who Completes/When Completed: The care coordinator completes the SAF when services or frequency of services are initiated..

Instructions:

Medicaid #: Enter client's Medicaid number. The Community Care Communicator, Form 5590, provides Medicaid number and amount of cost share for MAO clients. *Do not issue a SAF until a client has a Medicaid number.* Review the CCC for months of eligibility, if applicable.

Client's Name: Enter client's name as it appears on Medicaid card.

Soc. Sec. No: Enter client's social security number.

Services Begin Date: Enter date from CCNF that client received first CCSP waivered service.

Services Authorized: Enter provider's complete name, each CCSP service authorized and the appropriate service procedure code.

Month: Enter month and year for each month authorized. Care coordinators may authorize services up to three consecutive months. A newly approved MAO client may require more than one form to authorize CCSP services retroactively.

Units: Enter number of units of service authorized for each service listed.

Client Liability: Enter cost share amount for each month in Client Liability column on line for provider(s) assigned to collect cost share. Begin assigning cost share to the provider(s) who delivers services with the highest dollar amount authorized. Continue to assign cost share to providers until the entire cost share is assigned. The CCC, Form 5590 indicates amount of client's cost share and effective date(s) for liability amount(s).
Enter entire cost share amount even if it exceeds cost of all CCSP services. Enter 0 if client liability is zero.

Enter 99999 as the procedure code, below the row in which you list the provider enrollment number, name, procedure code, etc., for each provider assigned to collect cost share. This identifies all providers and the amount each will collect for the purpose of data entry and SAF generation.

EXAMPLE:
Services Authorized Month

Provider Name	Procedure Code	Units	Client Liability
Visiting Nurses Health Systems, Inc.	Y3801	4	$32.50
Visiting Nurses Health Systems, Inc.	99999		$32.50
Nursing Care, Inc.	Y3832	60	$367.50
Nursing Care, Inc.	99999		$367.50

Care Coordinator: Care coordinator signs form.

Date: Care coordinator dates form when s/he signs it.

Distribution: The completed data entry form is filed in the case record after the care coordinator has verified its accuracy.

Georgia Department of Human Resources

COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section I - A. Identifying Information	2. Patient's Name (Last, First, Middle Initial):
1. **CCSP ASSESSMENT TEAM NAME ADDRESS**	3. Home Address:
	4. Telephone Number; 5. County: 6. PSA:

7. Medicaid Number	8. Social Security Number				9. Mother's Maiden Name:		
	10. Sex	11. Age	12 Birthday	13. Race	14. Marital Status	15. Type of Recommendation 1. ☐ Initial 2. ☐ Reassessment	16. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Resources with necessary information including medical data.

17. Signed _____ 18. Date_____

(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation, and Nursing Care Needed	1. ICD	2. ICD	3. ICD
19. Diagnosis on Admission to Community Care (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____ 20. Is Patient free of communicable disease? 1 ☐ Yes 2 ☐ No			

Medications (including OTC)				Diagnostic and Treatment Procedures
21. Name	Dosage	Route	Frequency	22 Type Frequency

23. **COMMUNITY CARE SERVICES ORDERED** :

24. **Diet**	25. **Hours Out of Bed Per Day**	26. **Overall Cond**	27 **Restorative Potential**	28. **Mental and Behavioral Status**		
☐ Regular	☐ Intake ☐ IV	☐ Improving	☐ Good	☐ Agitated	☐ Noisy	☐ Dependent
☐ Diabetic	☐ Output ☐ Bedfast	☐ Stable	☐ Fair	☐Confused	☐ Nonresponsive	☐ Independent
☐ Formula	☐ Catheter Care	☐ Fluctuating	☐ Poor	☐ Cooperative	☐ Vacillating	☐ Anxious
☐ Low Sodium	☐ Colostomy Care	☐ Deteriotating	☐ Questionable	☐ Depressed	☐ Violent	☐ Well Adjusted
☐ Tube Feeding	☐ Sterile Dressings	☐ Critical	☐ None	☐ Forgetful	☐ Wanders	☐ Disoriented
☐ Other	☐ Suctioning	☐ Terminal		☐ Alert	☐ Withdrawn	☐ Inappropriate

29. **Decubiti**	30, **Bowel**	31. **Bladder**	32. **Indicate Frequency** Per Week: **Physical Therapy**	**Occupational Therapy**	**Remotive Therapy**	**Reality Orientation**	**Speech Therapy**	**Bowel Bladder Retrain**	**Activities Program**
☐ Yes	☐ Continent	☐ Continent							
☐ No	☐ Occas, Incontinent	☐ Occas Incontinent							
☐ Infected	☐ Incontinent	☐ Incontinent							
☐ On Admission	☐ Colostomy	☐ Catheter							
☐ Surgery Date									

33 **Record Appropriate** Legend
1. Severe
2. Moderate
3. Mild
4. None

IMPPAIRMENT

Sight	Hear	Speech	Ltd Motion	Para-lysis
☐	☐	☐	☐	☐

ACTIVITIES OF DAILY LIVING

1. Dependent
2. Needs Asst,
3 Independent
4. Not App

Eats	Wheel-Chair	Trans-fers	Bath	Ambu-lation	Dressing
☐	☐	☐	☐	☐	☐

34.. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

35. I certify that this patient ☐ requires ☐ does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for Community Care.

37. Physician's Signature _____

38. Physician's Name (Print)

39. Physician's Address (Print)

40. Date Signed By Physician	41. Physician's Licensure No.	42. Physician's Phone No.

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care ☐ Yes ☐ No 44. L.O.S. Certified Through Date

45. Signed by person certifying LOC: Title Date Signed

Instructions
Community Care Services Program

LEVEL OF CARE

Purpose: The Level Of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for Community Care or other services. In addition, the LOC page represents the physician's order for all waivered services provided by CCSP.

Who Completes Form: Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by RN and/or the social services worker. However, the LOC is always assigned by the RN. The client's physician participates in all assessments and reassessments by completing designating sections of the LOC page and signing the form.

When the Form is Completed:
The care coordinator completes the LOC page at initial assessments and reassessments.

Instructions:

SECTION I A. IDENTIFYING INFORMATION
Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address, telephone number, including area code, of care coordination team.

2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.

3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.

4. Enter client's area code and telephone number.

5. Enter client's county of residence.

6. Enter planning and service area (PSA) number where client resides.

7. Enter client's Medicaid number exactly as it appears on the Medicaid card.

NOTE: Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

8. Enter client's nine-digit social security number.
9. Enter client's mother's maiden name.

10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).

13. Enter client's race as follows:
    A = Asian/Pacific Islander H = Hispanic W = White
    B = Black NA = Native American

14. Enter client's marital status as follows:
    S = Single M = Married W = Widowed
    D = Divorced SP = Separated

15. Check (T) appropriate type of recommendation:
    1. Initial: First referral to CCSP or re-entry into CCSP after termination
    2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.

16. Enter referral source by name and title (if applicable), or agency and type as follows:
    MD = Doctor S = Self HHA = Home health agency
    NF = Nursing facility FM = Family PCH = Personal Care Home
    HOSP = Hospital ADH = Adult Day Health
    O = Other (Identify fully)
    DFCS = Department of Family & Children Services

17, 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

SECTION IB. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION
Section B is completed and signed by licensed medical person completing medical report.

19. The physician or nurse practitioner enters client's primary, secondary, and other (if applicable) diagnoses.

NOTE: After the physician or nurse practitioner returns signed LOC page, care coordination team indicates ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local hospitals or client's physician.

20. The physician or nurse practitioner checks appropriate box to indicate if client is free of communicable diseases.

21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.

22. List all diagnostic and treatment procedures the client is receiving.

23. List all waivered services ordered by care coordination team.

    NOTE: Waivered services ordered by care coordination and approved by the physician are considered physician's orders for CCSP waivered services.

24. Enter appropriate diet for client. If "other" is checked (√), please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. (Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.)

25. Enter number of hours out of bed per day if client is not bedfast. Check (√) intake if client can take fluids orally. Check (√) output if client's bladder function is normal without catheter. Check (√) all appropriate boxes.

26. Check (√) appropriate box to indicate client's overall condition.

27. Check (√) appropriate box to indicate client's restorative potential.

28. Check (√) *all* appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.

29. Check (√) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.

30. Check (√) appropriate box.

31. Check (√) appropriate box.

32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.

33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance needed.

34. Care coordination team or the admitting/attending physician indicates whether client's condition could or could not be managed by provision of Community Care or Home Health Services by checking (√) appropriate box..

    NOTE: If physician indicates that client's condition cannot be managed by provision of

Community Care and/or Home Health Services, the physician may complete and sign a DMA-6

35. Care coordination team or the admitting/attending physician certifies that client requires level of care provided by an intermediate care facility.

36. Admitting/attending physician certifies that CCP, plan of care addresses patient's needs for Community Care. If client's needs cannot be addressed in CCSP and nursing facility placement is recommended, the physician may complete and sign a DMA-6.

37. This space is provided for signature of admitting/attending physician indicating his certification that client needs can or cannot be met in a community setting. **Only a physician (MD or DO) or nurse practitioner may sign the LOC page.**

NOTE: Physician or nurse practitioner signs within 60 days of care coordinator's completion of form. Physician or nurse practitioner's signature must be original. Signature stamps are not acceptable. UR will recoup payments made to the provider if there is no physician's signature. "Faxed" copies of LOC page are acceptable.

38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided.

NOTE: The date the physician signs the form is the service order for CCSP services to begin. UR will recoup money from the provider if date is not recorded.

43, 44, 45. REGISTERED NURSE (RN) USE ONLY

43. The registered nurse checks (√) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.

44. LOS - Indicate time frame for certification, i.e., 3, 6, 12 months. LOS cannot exceed 12 months.

Certified Through Date - Enter the last day of the month in which the length of stay (LOS) expires.

45. Licensed person certifying level of care signs in this space and indicates title (R.N.) and date of signature.

NOTE: Date of signature must be within 60 days of date care coordinator completed assessment as indicated in Number 18. Length of stay is calculated from date shown in Number 44. The RN completes a recertification of a level of care prior to expiration of length of stay.

Distribution: The original is filed in the case record. Attach a copy with the CCC to DFCS at initial assessment and reassessment. Include a copy with the provider referral packet.

Sample Letter

CCSP Office
Letterhead

Telephone Number (____)_____
Date_____

Applicant Name_____

Address _____

_____

_____

NOTICE
DENIAL OF LEVEL OF CARE
COMMUNITY CARE SERVICES PROGRAM

State and federal law require that if you receive care in the Community Care Services Program, your medical condition must be such that you require the level of care provided in a nursing facility. This letter is to notify you that according to our evaluation, your medical condition does not require the level of care provided in a nursing facility because_____

_____

_____

_____

In accordance with the Code of Federal Regulations, 42 CFR, S 441.301(b)(l)(ii), services for you through the Community Care Services Program will be denied unless additional medical information justifies a need for the services.

You may obtain a review of this decision by sending additional medical information within ten (10) days of the date of this letter. Contact your attending physician or your original referring agency if you need help with your request. You must submit all information to the Community Care Services Program at the address shown above.

If you do not send additional medical information within ten (10) days, this decision will become effective on_____. If you choose not to send additional medical information but you disagree with this denial, you may request a hearing. You have thirty (30) days from the date of this letter to request a hearing. If you make your request orally, you must submit a written request within fifteen (15) days from the date of your oral request. An Administrative Law Judge will conduct the hearing in your county. At that hearing, you may represent yourself or use legal counsel, a friend, a relative or any other spokesperson to represent you.

You should contact this office immediately at the address and phone number above to request a hearing. The office will forward your request for a hearing to the Legal Services Office of the Georgia Department of Human Resources.

Sincerely,

Care Coordinator_____

Title_____

Telephone Number (___)_____

cc Area Agency on Aging (Name)

Instructions
Community Care Services Program

NOTICE OF DENIAL OF LEVEL OF CARE - COMMUNITY CARE SERVICES PROGRAM (CCSP)

Purpose: This form is used to notify applicants that evaluation of their medical condition does not require the level of care provided in a nursing home.

Who Completes/When Completed: This form is completed by the care coordinator RN and mailed to the client immediately after the RN determines that the applicant does not meet the level of care.

Instructions:

1. Use the care coordination agency letterhead stationary with the information in the sample letter to notify applicants of the denial of level of care.

2. Telephone Number: Enter the telephone number of the care coordination agency.

3. Date: Enter the date the notice was prepared and mailed.

4. Applicant's Name: Enter the applicant's name.

5. Address: Enter the applicant's mailing address.

6. Denial Reason: State specifically in the space provided why the applicant does not meet the level of care.

7. Effective Date: Enter the last day for which the applicant may submit additional information for reconsideration of the denial decision. This date is 10 days from the date the denial letter was prepared and mailed.

8. Sincerely: Enter the signature of the person authorized to sign on behalf of the agency.

9. Care Coordinator: Enter the name of the care coordinator RN who assessed the applicant and denied the level of care.

10. Title: Enter the title of the care coordinator RN.

11. Telephone Number: Enter the telephone number of the care coordinator RN who assessed applicant and denied the level of care.

Distribution: Original to the client, copy to the AAA, copy filed in applicant's case record.